UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
XYREM (Sodium Oxybate)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Extensions and

options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

---

FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA

- **DOCUMENTED** cataplexy associated with narcolepsy**.**
- **DOCUMENTATION** ruling out concomitant use of sedatie-hypnotics**.**
- Age requirement: 18-65 years old.
- **Maximum dose:** 9gm/day

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Telephone request from physician's office or pharmacy.

The Department regards adequate clinical records as essential for the delivery of quality care, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the Utah Medicaid criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.

Physician Signature_____Date of Submission_____